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	345351	A. BUILDING _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALUDA	501 ESSEOLA CIRCLE SALUDA, NC 28773

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted from 12/11/22 through 12/12/22. Event ID# NF1611. 2 of the 2 complaint allegations resulted in deficiency. Event ID#NF1611.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Nurse Practitioner (NP), Director of Nursing (DON) and Administrator, the facility failed to protect the resident's right (Resident #1) to be free of abuse when Resident #2's family member (facility Housekeeper) pulled Resident #2's TV remote from Resident #1's hands. Resident #1 sustained a fracture of his left index finger that required no surgical intervention. This deficient practice occurred for 1 of 1 resident reviewed for abuse.	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/02/2024

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Findings Included:

Resident #1 was admitted to the facility on 5/25/17 with diagnoses including stroke, paralysis of the right side and legal blindness.

Resident #1's quarterly Minimum Data Set (MDS) dated 11/2/23 coded Resident #1 as severely cognitively impaired with no behaviors noted.

Resident #1 was care planned (2/7/23) for altered or at risk for altered behaviors and/ or mood with a history of yelling, cursing, paranoid, history of cycling through roommates, history of many room changes due to anger, and behavior. Resident non-compliant with care. Resident with a history of suddenly becoming angry and verbally aggressive with roommates and history of hoarding objects. Interventions included to allow the resident to vent his thoughts and feelings. Use reorientation, validation. Approach in a calm, relaxed manner. Identify what helps calm the resident down when upsent such as snacking, talking, reminiscing, walking, and reapproaching.

The Activities Assistant was interviewed on 12/12/23 at 10:06 AM and stated that she was working on 11/12/23 but was unable to remember what time the interaction with Resident #1 had occurred. The Activities Assistant said she walked into Resident #1's room to take him to an activity. She noticed Resident #1 had a TV remote laying in his lap. The Activities Assistant asked Resident #1 to leave the TV remote for his roommate (Resident #2) to use while he was in the activity. Resident #1 then stated to the activities assistant he was not leaving the TV remote with that "f--- retard". The activities assistant told Resident #1 he should not talk to

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Resident #2 that way and then took Resident #1 to the nursing station to calm down. She saw Resident #2's family member/housekeeper who was working in housekeeping at the facility on 11/12/23. She asked the family member if the TV and TV remote belonged to Resident #2, and he stated yes, and Resident #1 does not share it. The Activities Assistant stated she did not witness or hear any altercation with Resident #2's family member and Resident #1.

Resident #2's family member/housekeeper's statement dated 11/12/23 was reviewed and read in part as follows. On 11/12/23, the Family Member had an altercation with Resident #1. The Family Member spoke with Resident #1 when his shift as a housekeeper had ended. The Family Member told Resident #1 the TV remote and TV was Resident # 2's, and he needed to share it. The Family Member said to Resident #1, I heard you are having a bad day and I hope it gets better for you. Resident #1 replied to the Family Member that he was not having a bad day; it was the retard that was having a bad day as Resident #1 pointed towards Resident #2. The Family Member wrote he reached for the TV remote the Resident #1 was holding, and Resident #1 pulled the remote up to his chest and grabbed the remote with both hands. The Family Member pulled the bottom of the remote down from Resident #1. The Family Member wrote he did not grab Resident #1's finger or attempt to break it. After freeing the TV remote, the Family Member rolled Resident #1 to the nurses' station and told Nurse #2 Resident #1 needed to stay in a different room as Resident #1 was calling Resident #2 a F----retard". The Family Member wrote he was not mad at Resident #1 and he wished the best for Resident #1.

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Resident #2's family member was not available for interview.

Resident #1's assigned Nurse #2 on 11/12/23 was interviewed on 12/12/23 at 9: 23 AM. Nurse #2 stated Nurse Aide (NA) #1 notified her that Resident #1 had been speaking ugly to his roommate. Nurse #2 was going back towards the nursing station, when she saw Resident #2 and his family member/housekeeper leaving the room. The family member told Nurse #2 that Resident #1 had said to Resident #2 he was retarded, and the family member did not want Resident #1 to remain in the room with Resident #2. The family member did not mention there had been an incident with Resident #1. Nurse #2 then notified the Unit Manager about Resident #1's language toward Resident #2, and the Unit Manager instructed Nurse #2 to move Resident #1 to a different room. Nurse #2 stated she moved Resident #1 to another room, and Resident #1 did not mention an altercation with Resident #2's family member or complain of any pain or discomfort to his hand or finger.

Nurse #1 stated in an interview on 12/11/23 at 3:40 PM on 11/13/23 sometime after breakfast, she was notified by Nurse #2= that Resident #1's hand was swollen and bruised. Nurse #1 stated she asked Resident #1 what had happened to his hand. Resident #1 told her Resident #2's family member tried to break his fingers. Nurse #1 said she notified the Director of Nursing (DON), and the DON told her to get an order for an x-ray of his hand.

NA #1 was interviewed on 12/12/23 at 9:12 AM and stated she was working on 11/13/23 as a

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Medication Aide and noticed Resident #1's left hand and finger was bruised and swollen. NA #1 stated she notified Nurse #1 about Resident #1's hand.

The Unit Manager wrote a progress note dated 11/13/23 at 4:31 PM that read in part Resident #1 was brought to Nurse #1 with discoloration of left index finger. Resident #1 was asked what happened and the resident stated his roommates' family member tried to break his finger. Resident #1's left index finger was noted to be purple/red with edema noted into hand. The Nurse Practitioner (NP) was notified, and an order was received for a left-hand x-ray. Resident #1's pain level was 2 out of 10.

A review of Resident #1's radiological report dated 11/14/23 found a fracture on the second finger of the left hand. The fractured finger was not displaced.

A review of Resident #1's orthopedic progress noted dated 11/15/23 confirmed a fractured left index finger. The treatment plan was to buddy tape the bases of the middle finger and index finger for 1 month and change the tape as needed.

The NP progress note dated 11/14/23 was reviewed. The progress note read in part Resident #1 was being seen for left hand and index finger bruising and swellings. An urgent orthopedic referral was placed. Therapy will screen and provide stabilization until the appointment with orthopedics. On exam, Resident #1's pain appears mild and had prn Tylenol available. A request for a psychiatry consult to see the resident and evaluate for any

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post-traumatic stress concerns.

The NP who assessed Resident #1 was interviewed on 12/12/23 at 1: 06 PM. The NP stated she assessed Resident #1 on 11/13/23. The NP stated the resident had obvious bruising on his middle-left finger along the side and on the palm of his left hand and Resident #1 was able to make a fist with his hand. The NP stated Resident #1 told her his roommates family member tried to break his finger. The NP said the x-ray came back positive for a fracture, and the following day (11/15/23) the Resident went to see orthopedics who gave orders to buddy tape his affected finger. The NP stated Resident #1 did to go to the hospital, had mild pain and a standing order for Tylenol and was not sure how often he was taking it.

A review of Resident #1's Medication Administration Record (MAR) for November and December 2023 revealed Resident #1 received Tylenol on 11/16/23 and 11/19/23.

On 12/11/23 at 10:45 AM Resident #1's left middle and index fingers were observed to be tapped together. Resident #1 did not appear in any pain or distress. Resident #1 was not able to recall the incident.

Resident #2 was interviewed on 12/11/23 at 3:12 PM and was not able to recall the incident.

A review of nursing progress notes dated 11/14/23 written by the DON read on 11/12/23 the Unit Manager was notified Resident #1 was not getting along with his roommate. The Unit Manager instructed Nurse #2 to move Resident #1 to another room for the night. On 11/13/23 at

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approximately 3:30 PM NA #1 brought the resident to the Unit Manager with concern of bruising and swelling noted on the left index finger as well as the left palm of the hand. The DON was notified and instructed the Unit Manager to notify the NP and obtain an order for an X-ray. DON notified Administrator and an immediate investigation began. When speaking to Resident #1 he stated, his roommate's family member tried to break his finger. Resident #1 had not verbalized anything prior to this. Resident #1 had no complaints of pain. The Administrator notified Resident #2's family member (also employed by housekeeping) of suspension pending investigation. The completed X-ray noted an acute fracture involving the medial corner of the proximal phalanx of the left second finger. Resident #1 was ensured to be safe. A head-to-toe assessment completed on Resident #1 with no other concerns noted. The initial state report was completed. The Saluda police notified with a police investigation initiated. A message was left for Resident #1's adult protective services guardian to call the facility. Resident/Staff interviews initiated. Psych services notified. Head to toe skin assessments completed on residents with a BIMS score less than 12 with no issues or concerns for further abuse noted. Abuse policy education-initiated facility wide and completed. Resident #2's family member/housekeeper was interviewed by Administrator and DON and currently remains suspended.

The Administrator and DON were interviewed together on 12/12/23 at 2:37 PM. The DON stated the nursing Unit Manager called her on 11/12/23 in midafternoon to report Resident #1 and his roommate were not getting along. The

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DON stated she instructed the Unit Manager to move Resident #1 to another room for the night. The next day, on 11/13/23 an NA noticed Resident #1's finger and hand was swollen and bruised. The Unit Manager looked at Resident #1's hand and notified the DON. Resident #1 told the Unit Manager that Resident #2's family member/housekeeper tried to break his finger. The DON said the NP was then called to get an x-ray order and to assess Resident #1. The DON stated the Administrator was notified about the incident, and Resident #2's family member/housekeeper was suspended immediately after being interviewed and pending an investigation, and was terminated on 11/17/23. Resident #1 was interviewed by multiple facility staff and his story was consistent. Resident #1 told DON and other staff that his roommates family member who worked as a housekeeper had tried to break his finger. The DON stated Resident #1 had a complete head to toe assessment completed on 11/13/23 that did not find anything additional. The Administrator stated he notified the police of the incident that the investigation included interviewing staff who might have seen or heard anything. The Administrator stated that the investigation revealed the incident occurred on 11/12/23 and was witnessed by Resident #1's roommate and the family member/housekeeper. The Administrator stated the family member told him he went to Resident #1's room to tell Resident #1 that the TV remote belonged to Resident #2, and he needed to share it. Resident #1 told the family member he was not giving the TV remote to that "F----retard". The family member went to take the TV remote from Resident #1, and Resident #1 held on to the remote with both hands while the family member pulled the TV remote from Resident #1. Resident

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#2's family member/housekeeper stated he did not intend to hurt the resident and the resident did not complain of any pain.

The facility provided the following corrective action plan with a completion date of 11/17/23.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 11/12/23, Unit Manager was notified Resident #1 and his roommate (Resident #2) were not getting along by Charge Nurse, Resident #1 was immediately moved to another room. On 11/13/23 Unit Manager was notified Medication Aide of swelling and bruising of Resident #1's Left Index Finger. Head to toe assessment completed of Resident #1 on 11/13/23 and no other injuries were noted. Resident #1 stated "dead head" tried to break my finger, who Resident #1 identified as the Resident #2's family member/housekeeper. With bruising noted we also had an allegation of abuse on Resident #1, staff member was immediately notified and suspended on 11/13/23 and told not to come to the building until interviewed by Administrator and Director of Nursing. Police and Adult Protective Services notified on 11/13/23 due to bruising on left hand of Resident #1 and residents' #1's statement regarding the incident. Two View X-Ray completed of Resident #1's left hand on 11/13/23 and noted an acute fracture of the left second finger. Nurse Practitioner ordered Urinary Analysis for Resident #1 on 11/14/23, also ordered therapy consult and sent order for therapy referral. Resident #1 went to an orthopedic appointment on 11/15/23 with new orders to buddy tape fingers. Psych referral

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initiated on 11/14/23 via tele-visit, medication changes initiated for Resident #1. Staff member was terminated on 11/17/23 following investigation.

An initial report for the allegation of abuse was reported on 11/13/23 and our investigative report was reported on 11/17/23, which substantiated the allegation.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

Social Worker conducted interviews and educated all alert and oriented residents on November 14, 2023 on abuse and neglect and how to report abuse and neglect with no concerns noted. Director of Nursing completed skin checks on all residents with a BIMs score of 12 or less (impaired cognition) on November 13, 2023, with no concerns noted. Staff interviews initiated regarding the incident on 11/13/23.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Director of Nursing/Designee educated all staff including agency staff and as needed staff on 11/13/23 on abuse and neglect policy and reporting. This education was completed in person or via phone for those not working or on leave of absence, these individuals were required to sign the attendance sheet when they returned to work. Two Educational programs were added to Relias program (Staff Education On-Line) on 11/14/23, "Abuse, Neglect and Exploitation in the Elder Care Setting" and "Recognizing Abuse,

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Neglect and Exploitation". These programs include a final exam that staff member must score an 80 or above to pass the course. This training included recognizing abuse, neglect and exploitation as well as reporting abuse, neglect and exploitation. It also included training on care giver burnout, risk factors for committing abuse, preventing abuse. The course titled "Abuse, Neglect, and Exploitation in the Elder Care Setting" also included education on person centered care and providing care to residents regarding approaching those residents with behaviors. This education was completed by all staff by 11/17/23. New hires will be educated upon hire.

During Concierge rounds, which are rounds completed by facility managers Monday through Friday, of assigned rooms and residents, managers will monitor for abuse and care concerns and report immediately to their supervisor, this will be added to their round sheets for monitoring. The Supervising Nurse or Manager on Duty will complete these rounds on the weekends.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Administrator/Designee will complete three staff interviews weekly for 4 weeks and monthly for two months on what to do if they see or hear abuse and who to report it to and how to deal with difficult or agitated residents.
Director of Nursing/Designee will interview 5 residents weekly for 8 weeks then monthly for three months to ensure there are no issues with abuse/neglect with the residents.

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Director of Nursing/Designee will conduct observations of 3 residents weekly for four weeks then monthly for two months of Certified Nursing Assistants interactions with residents to ensure no issues with abuse/neglect.
Results of the interviews/audits will be presented monthly to the QAPI committee meeting by the Director of Nursing/Designee for review/revision as needed for three months.

5. Include dates when corrective action will be completed. November 17, 2023

The facilities action plan was validated on 12/12/23 and confirmed the compliance date of 11/17/23. concluded the facility had implemented an acceptable corrective action plan effective on 11/17/23. The corrective action plan was validated by the following:

1.On 12/11/23 a review of the initial report for the allegation was verified reported on 11/13/23 and concluded on 11/17/23.
2. Every resident had a head-to-toe assessment completed and was verified.
3. On 12/11/23 and 12/12/23 interviews with facility staff and agency staff verified they had received education on abuse and neglect.
4.On 12/11/23 and 12/12/23 interviews with alert and oriented residents verified they had been provided with education on abuse and neglect.
5.A review of the facilities monitoring book verified three staff interviews had been conducted weekly for 4 weeks. Further review found 5 residents had been interviewed weekly and ongoing for 8 weeks to ensure no concerns with abuse and neglect. The DON or designee had conducted observations of 3 residents with NAs for 4 weeks with no concerns of abuse or neglect.

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F 600	Continued From page 12 6.Resident #2's family member was verified to be terminated from the facility on 11/17/23. 7. A review of the November QAPI verified the audits were included in the meeting. The compliance date of 11/17/23 was validated.	F 600		